# Commentary

## Toxic Intern Syndrome

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I made a promise to myself during medical school that it would not happen to me. My first priority would be patient care and my patients' well-being. I would treat them with respect and dignity. I was determined not to become inured to patients' requests and their pain, as had occurred with many of the interns and residents before me. I do not know exactly when it began, but I soon succumbed to "toxic intern syndrome."

The affliction was pointed out to me by a close friend who informed me midway through my intern year that he no longer wanted me as his physician. I had changed. The process was gradual, occurring over time, and was probably the result of coping with the reality and daily hassles of residency. The naïvete and compassion that I had as a medical student had been replaced by the ennui and callousness of a toxic intern. But I was not unique. Talking to other interns revealed that I was not the only one changing. I stepped back to examine what was happening.

The duration, severity, and onset of the syndrome are highly variable. Some interns contract it earlier in the year, some later, and others presumably exhibit immunity. It is difficult to predict whom or when it will hit or how long it will last.

The signs and symptoms also vary. The signs are expressions of fatigue—slumped shoulders, nodding off during meetings, and perpetual dark circles under the eyes. Irritability mixed with anger is a common symptom. Another is recurrent irritation with support staff, residents, attending physicians, consultants, patients, and hospital systems or the Department of Veterans Affairs (VA). Depending on the duration of the irritating stimulus or the cumulative effects of multiple aggravating situations, this can create irrational and illogical behavior. The behavior frequently manifests in the form of "scapegoating" (yelling at the wrong nurse for an order not completed or blaming them for the intern's own omission), venting anger at a staff member or technician who had nothing to do with the original problem, or raising his or her voice in frustration to patients. Scapegoating is also used against friends, family, and loved ones as the toxic intern takes frustrations from work out on someone at home who has no control or influence over any of it.

The symptoms can occur in a passive-aggressive form, such as striking back at residents, nurses, and patients. Typically they involve an order or test inadvertently "forgotten." Or they may occur as a slow response to nurses for ridiculous crosscover calls. Or a patient may be allowed to leave the hospital against medical advice with no attempt made to persuade the patient to stay.

A pervasive cynicism develops as another means of coping. By now the emphasis has shifted from helping others to conserving energy and managing time efficiently. This is evident in the language used. Patients are viewed as "hits," and residents complain about getting "slammed" on call with admissions. Patients may be checked out as being "stable," only to "go bad" soon after their team is out of the hospital. The "dumps" take on many forms. The chronic-care or nursing home patient is "dumped off" before long weekends to become the responsibility of the hospital. Patients can also be "dumped" within departments, from one service to another and from one hospital to another. The classic example is the male veteran who is emergently transferred to the VA hospital once a military service record is established. Patients are described as "wimps," "drug-seekers," "gomers," and "worthless scum."

Survival becomes a peculiar game, one that frequently neglects patients' best interests. The goal is not to admit patients, but rather to "bounce" or "turf" them to other services, to reject transfers, and to immediately discharge when a patient's condition becomes stable. The game may necessitate coercing other departments into providing the consultation or needed tests. On weekends or after hours at the VA hospital, it means relying on hope and prayer that patients will not get sick, because it requires even more than the normal hassle to get basic laboratory or x-ray tests done.

The cause of the syndrome is relatively clear—too much "scut" work (some common unfinished task), too little pay, and too many hours spent in the hospital. The hours are frequently spent dealing with patients' social issues rather than medical illnesses. Nursing home candidates cannot be placed because of lack of funding or "undesirable characteristics," so they stay until a nosocomial infection occurs, necessitating an even longer stay in the hospital. Alcoholic patients initially present with massive gastrointestinal bleeding, are transfused, treated, and released, only to return bleeding again after yet another drinking binge. Gang members are admitted with gunshot wounds after an altercation; rival members must be sepa-

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rated in the hospital and visitors carefully monitored. Intravenous drug injectors present with skin-popping abscesses demanding high doses of pain medication for minor dressing changes or develop a new heart murmur or endocarditis, buying a six-week in-house course of intravenous antibiotics.

By this time the syndrome has taken its toll. Now the toxic intern forces patients to walk on postoperative day one and listens to intravenous drug injectors and patients with gunshot or stab wounds complain without increasing their pain medication. (The downside to this is that suddenly everyone is suspected of drug-seeking behavior.) The toxic intern will interrupt patients during long, rambling historical recounts, forcing them to get to the point. The intern becomes oblivious to pain elicited during procedures, while incising and draining drug-induced abscesses, during lumbar punctures or paracenteses, and while placing central venous lines. Disability benefits are denied to those wanting them for back pain, gunshot wounds, or obesity. The toxic intern gradually resents the sense of entitlement found in many medicaid patients who want everything done, but who are frequently the most noncompliant and have contributed little for their medical treatment.

Unfortunately there may not be a cure, short of stopping the toxic impulses before they occur. Once a person becomes infected with the toxic intern syndrome, she or he is never the same. It becomes a strong coping mechanism for internship and residency, providing interns with the ability to turn off their emotions. Survival, not patient care, becomes the first priority. There are periods of exacerbation and remission during residency that usually subside once a person enters private practice. For those who stay in academia, there is the protective effect of being an attending physician, keeping them insulated from daily problems, and allowing them to remain relatively free of symptoms.

The only effective treatment is prevention. This would require restructuring much of the current health care system. Medicaid, medicare, health care for the indigent and illegal aliens, and insurance programs would all need to be revised into a more user-friendly system, one less susceptible to misuse and abuse. It would also require revamping residency programs, limiting work hours, and creating a pay scale with benefits (an unlikely event because of the cost).

The frustration of trying to cope with daily battles, coupled with constant stress and fatigue, eventually leads to resignation, the realization that the system will not change, and finally complacency. The ultimate coping mechanism is to just sit back, relax, and take it. It is easier than constantly fighting. The toxic intern can only hope that recurrences are short-lived and that patients, in the long run, do not suffer too much.